

STATE OF MICHIGAN

IN THE SUPREME COURT

Appeal from the Court of Appeals
Borello, P.J., and Jansen, and Cooper, JJ.

COMMUNITY RESOURCE CONSULTANTS,
INC.,

Plaintiff-Appellee,

v

PROGRESSIVE MICHIGAN INSURANCE
COMPANY,

Defendant-Appellant

Supreme Court No. 133416

Court of Appeals No. 269726

Ingham County Circuit Court
No. 04-000879-CK

AMICUS CURIAE BRIEF OF THE
COALITION PROTECTING AUTOMOBILE NO-FAULT ("CPAN")

MILLER & TISCHLER, P.C.
BY: WAYNE J. MILLER (P31112)
Attorneys for Coalition Protecting Automobile
No-Fault (CPAN)
26711 Northwestern Hwy., Suite 200
Southfield, MI. 48033-2159
(248) 945-1040

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STATEMENT OF THE BASIS OF JURISDICTION

Defendant-Appellant, Progressive Michigan Insurance Company (“Progressive”) timely filed its application for leave to appeal from the February 1, 2007 judgment of the Court of Appeals. On September 14, 2007, this Honorable Court entered an Order granting the application for leave to appeal. In this Order, the Court asked the parties to submit supplemental briefs addressing the following issue: whether, for purposes of MCL 500.3145(1), a loss is incurred at the time the treatment or services are provided, rather than at the time a bill is submitted for the treatment or services in question. CPAN submits this *amicus curiae* brief in response.

INTERESTS OF THE *AMICUS*

The Coalition Protecting Automobile No-Fault (“CPAN”) is an organization aimed at sustaining vital benefits for injured victims under the Michigan Automobile No-Fault Insurance Act. Specifically, CPAN is geared towards maintaining the protection of the no-fault law that affords payment of unlimited lifetime medical and rehabilitative expenses for all persons who suffer injuries in motor vehicle accidents. Various medical provider groups and consumer organizations have banded together to promote the mission statement of CPAN:

Medical Provider Groups	Consumer Organizations
Michigan Academy of Physicians Assistants	Brain Injury Association of Michigan
Michigan Assisted Living Association	Disability Advocates of Kent County
Michigan Association of Centers for Independent Living	Michigan Paralyzed Veterans of America
Michigan Brain Injury Providers Council	Michigan Partners for Patient Advocacy
Michigan Chiropractic Society	Michigan Protection and Advocacy Services
Michigan College of Emergency Physicians	Michigan Rehabilitation Association
Michigan Dental Association	Michigan Citizens Action
Michigan Health & Hospital Association	Michigan Consumer Federation
Michigan Home Health Care Association	Michigan State AFL-CIO
Michigan Orthopedic Society	Michigan Association for Justice
Michigan Orthotics and Prosthetics Association	Michigan Tribal Advocates
Michigan Osteopathic Association	Michigan UAW
Michigan State Medical Society	American Association of Retired Persons
Michigan Nurses Association	

The interests of the professional service providers are directly implicated in this case. These service providers include: hospitals, physicians, nursing facilities, as well as other individuals and agencies who render care to injured people. The date/timing on which treatment or service is deemed to be “incurred” has great significance in a variety of contexts in Michigan No Fault Law. Most notably, when a service is deemed to be “incurred” determines the timing of the no-fault “one year back” damages limitation contained in MCL 500.3145. Interpreting “incurred” to occur at the time the service is rendered, as opposed to when the bill is computed and generated, will obviously shorten an already short period of limitations. The inevitable result will be that service providers will not be able to make appropriate decisions to pursue timely payment of charges. In a health care market place in which it is ever more difficult to maintain business viability, the concern over this issue by CPAN and its members is manifest.

STATEMENT OF FACTS

CPAN incorporates by reference Plaintiff-Appellee's statement of facts contained in the "Introduction" portion of its Supplemental Brief in this matter.

ARGUMENT

I. Service provider charges under the no-fault act are “incurred” when the charge is calculated and submitted.

A. Introduction

In its Order for action on application, the Court asked the parties to address the following issue: whether, for purposes of MCL 500.3145(1), a loss is incurred at the time the treatment or services are provided, rather than at the time a bill is submitted for the treatment or services in question. §3145 provides in pertinent part:

However, the claimant may not recover benefits for any portion of the loss **incurred** more than 1 year before the date on which the action was commenced.¹

We answer that the bill is not incurred until the bill is calculated and submitted, in the medical provider context. This Honorable Court recognized in *Griffith v State Farm*, 472 Mich 521; 697 NW2d895 (2005), that food provided to a patient in a hospital setting must be treated differently than food provided in the home. Similarly, when an expense is “incurred” in the medical service provider context may vary from when an expense is “incurred” in other contexts.

B. General Rules of Statutory Construction

The purpose of statutory construction is to ascertain and give effect to the Legislature’s intent behind enacting said statute. *People v Morey*, 461 Mich 325, 329-330; 603 NW2d 250 (1999); *Yaldo v North Pointe Ins Co*, 457 Mich 341, 346; 578 NW2d 274 (1998). The Court first examines the plain language of the statute because the words provide the most reliable evidence of its intent. *Gilbert v Second Injury Fund*, 463 Mich 866, 866; 616 NW2d 161 (2000). “[W]here that language is

¹ The term “incurred” occurs at various other places in the no-fault law, including §§3107(1)(a), 3107(1)(c), and 3110(4).

unambiguous, [it is] presume[d] that the Legislature intended the meaning clearly expressed - no further judicial construction is required or permitted, and the statute must be enforced as written.” *Morey, supra* at 330.

“Where the meaning of statutory language is not clear, judicial construction becomes necessary.” *Turner v Auto Club Ins Ass’n*, 448 Mich 22, 27; 528 NW2d 681 (1995) (citing *Mull v Equitable Life*, 444 Mich 508; 510 NW2d 184 (1994); *Coleman v Gurwin*, 443 Mich 59; 503 NW2d 435 (1993)). Courts are to ascertain and give the statutory words their plain and ordinary meaning. *Id.* The plain and ordinary meaning of words can be established by looking at dictionary definitions. *Koontz v Ameritech Services, Inc.*, 466 Mich 304, 312; 645 NW2d 34 (2002).

C. General Definitions of “Incurred” in No-Fault Jurisprudence to Date

The No-Fault statute does not define the term “incurred.” Our appellate courts have had occasion to contemplate the meaning of the term “incurred.” In general, these decisions have applied the dictionary to define incurred in its ordinary sense as meaning “to become liable for.” Though this definition is satisfactory, it is also incomplete, as it does not answer our question in this case: when does a person “become liable for” an expense; i.e., when is an expense incurred.

For example, in *Shanafelt v Allstate Ins Co*, 217 Mich App 625, 628; 552 NW2d 671 (1996), the Court of Appeals turned to a dictionary to determine the plain and ordinary meaning of “incur” because the term is not defined in the No-Fault Act. The Court stated that the word “incur” means “to become liable for” according to *Random House Webster’s College Dictionary* (1995). *Id.* at 638.

The Court departed from the dictionary to declare the following as to the timing of when she “became liable for” her medical expenses: “[o]bviously, plaintiff became liable for her medical expenses when she accepted medical treatment.” *Id.*

Respectfully, it is **not** obvious that the liability for medical expenses was established “...when she accepted medical treatment.” The court cited no authority or reasoning for what is regarded as an “obvious” proposition. That proposition is very much in dispute, and is the essence of the current appeal.

In *Bombalski v Auto Club Ins Ass’n*, 247 Mich App 536, 543; 637 NW2d 251 (2001), the Court of Appeals once again looked at the plain and ordinary meaning of “incur” and took it one step further than the court in *Shanafelt*. In *Bombalski*, the Court also looked to Black’s Law Dictionary (7th ed), p 771, “which similarly defines ‘incur’ as ‘to suffer or bring on oneself (a liability or expense).’” *Id.* The plaintiff here was arguing that he became liable for the full amounts charged by his medical providers when he accepted their services. *Id.*

However, unlike the Court in *Shanafelt*, the Court declined to follow the plaintiff’s argument. Rather, the Court stated:

[P]laintiff overlooks the significance of “liable,” which means “responsible or answerable in law; legally obligated.” Black’s Law Dictionary, *supra* at 927. The satisfaction of plaintiff’s medical bills by BCBSM through payment of less than the amounts charged by the providers relieved plaintiff of any responsibility or legal obligation to pay the providers further amounts exceeding those proffered by BCBSM and accepted by plaintiff’s health care providers. Because plaintiff bears no liability for the full medical service amounts initially charged by his health care providers, he has not incurred these full charges. *Id.* (citations omitted).

* * *

We therefore conclude that in light of the ordinary meaning of incurred and the public policy behind the no-fault act, incurred charges within MCL 500.3107(1)(a) do not encompass any amounts (1) exceeding those that plaintiff’s health insurer actually paid in satisfaction of plaintiff’s medical bills and (2) for which plaintiff no longer bears legal responsibility. [*Id.* at 546.]

In *Duckworth v Continental Nat’l Indemnity Co*, 268 Mich App 129, 131; 706 NW2d 215 (2005), the Court followed the same reasoning from *Bombalski* as it relates to the plain and ordinary

meaning of “incurred.” In *Duckworth*, the plaintiff was a Canadian citizen who received medical treatment paid for by a Canadian public health insurance program. *Id* at 130. Accordingly, the plaintiff was never directly billed and in fact was not liable for any up front costs regarding his medical care. *Id* at 135. The Court held that “[p]laintiff bore no legal responsibility for the disputed costs of his medical care and, accordingly, did not ‘incur’ the medical expenses reimbursable under the no-fault act.” *Id* at 136-137.

The decisions in *Bombalski* and *Duckworth* thus do not address the critical issue in the present case: when does one “become liable for” medical expenses; though they make clear that the determination of when one “becomes liable for” requires resort to legal authority, such as the resort to Black’s Law Dictionary in *Bombalski*.

D. The Timing of Liability is a Legal Question

As stated, the use of dictionary definitions by the Court when engaging in statutory interpretation is helpful in ascertaining the plain and ordinary meaning of words used by the Legislature. However, at issue in the present case is the question of when an expense is incurred. This is a timing issue that one is not able to determine through reference to a dictionary. Rather, rules of liability are legal questions with special meanings. Reference to the dictionary is not appropriate when the word at issue is one with special, not ordinary, meaning. *Krajewski v Royal Oak*, 126 Mich App 695, 697; 337 NW2d 635 (1983). Therefore, in order to properly assess the timing issue of when one “becomes liable for” medical expenses under the No-Fault Act, we must look to the law, in this case, the law of contracts, and more specifically, to the law of debtor/creditor accounts.

E. The Law of Accounts Establishes Liability Upon the Calculation of the Account

In the medical service provider context, the relationship between the provider and the injured person is essentially that of a creditor and a debtor, respectively. The injured debtor establishes an “account” with the provider/creditor. In general, an “account” is an unsettled claim or demand by one person against another, which creates a debtor-creditor relationship between them. See 1 Am Jur 2d, Accounts & Accounting, § 1, p 560; See also *State v Stout*, 142 W Va 182; 95 SE2d 639 (1956); *Kramer v Gardner*, 104 Minn 370; 116 NW 925 (1908). Similarly, an “open account” is one with a balance that has not been ascertained and which is kept open in anticipation of future transactions. See 1 Am Jur 2d, Accounts & Accounting, § 4, p 562; See also *Kugler v Northwest Aviation, Inc*, 108 Idaho 884; 702 P2d 922 (1985); *Kramer supra*.

An “open account” results where the parties intend that the individual transactions conducted between them are to be considered as a connected series, rather than independent of each other, for the purpose of a single and indivisible liability arising from their relationship. See generally, *Ray Jewelry Co v Darling*, 251 Mich 157; 231 NW 101 (1930); *Davis v Kramer Bros Freight Lines, Inc*, 373 Mich 594; 130 NW2d 419 (1964); *Hawley v Professional Credit Bureau, Inc*, 345 Mich 500; 76 NW2d 835 (1956). This single and indivisible liability is fixed at the time of settlement, or following the last entry in the account. See 1 Am Jur 2d, Accounts & Accounting, § 4, p 562; See also *Scott v House*, 120 Ind App 346; 91 NE2d 853 (1950); *Gentry v Gentry*, 59 NM 395; 285 P2d 503 (1955).

An action on an “account” must be founded on a contract, either express or implied. See 1 Am Jur 2d, Accounts & Accounting, § 8, p 567; See *Keywell & Rosenfeld v Bithwell*, 254 Mich App 300, 331; 657 NW2d 759 (2002); See generally *Ludwig Hommel & Co v Woodsfield*, 115 Ohio St 675; 155 NE 386 (1927); *Rocky Mountain Helicopters v Air Freight*, 773 P2d 911 (Wyo, 1989). The purpose of an action on account is to avoid the multiplicity of suits that would result if each transaction

between the parties to an account, or each item on the account, were construed as constituting a separate cause of action. *Rocky Mountain Helicopters, supra* pp 921-922; See also 1 Am Jur 2d, Accounts & Accounting, § 10, p 568; *Rosati v Heimann*, 126 Cal App2d 51; 271 P2d 953 (1954).

In the medical service provider context, there has been a routine and widely-accepted billing practice, like the billing practices involved in the present case. Medical service providers furnish necessary and life-saving services to the injured person. Often these services are rendered over an extended period of time. For example, in the case where an injured person suffers a brain injury and is hospitalized for several weeks and/or months, multiple services are rendered on a daily basis. However, the hospital does not bill the injured person or assess the value of these services at each moment they are rendered. Rather, the routine pattern and practice engaged in by medical service providers is the creation of an “account”, upon which a bill is computed after completion of all of the services.

Prior to the computation of the bill, the amount of the injured person’s liability is unknown. Stated another way, prior to the computation of the bill, there is no way to know the amount of the injured person’s liability. The injured person is liable for the value of the services rendered by the medical service provider, but that value is unknown until the bill is calculated at the conclusion of the hospital admission. The bill for these services represents the monetary expression of that value and determines the injured person’s liability. Accordingly, at the time the services are rendered, the injured person’s liability is an inchoate obligation that becomes complete once the bill is calculated and submitted.

The Defendant-Appellant, Progressive, argues that basic contract principles of “offer and acceptance” supports their assertion that a loss is incurred at the time services or treatment are

rendered. However, these mere principles alone still do not answer the timing question of “when” a loss is “incurred” for purposes of the No-Fault Act. Progressive claims that the moment an injured person receives a service or treatment, they have accepted all legal consequences flowing from that offer, which includes liability for payment of those services or treatment. Accordingly, argues Progressive, the injured person’s liability is that they are legally obligated to pay right at that moment. The critical problem with Progressive’s analysis is that the injured person cannot pay at the moment that service is received.

Medical service providers are not equipped to accept payment from injured persons at every moment a service or treatment is rendered. For example, an injured person may have blood drawn, blood pressure taken, and x-rays performed all in the same day. Is it possible to pay the nurse the minute she is done drawing the blood? Is it possible to pay the nurse the moment she is finished taking the blood pressure? Can a person pay for an x-ray at the moment the radiologist takes it? The simple and logical answer is no: the nurse does not stand there with hand out to collect payment. Nor would the patient account office be able to accept payment on an account that has not yet been computed. Rather, it is understood that the amount of the charge is unknown, and payment is not expected, until a bill is calculated and submitted. Accordingly, the injured person’s “incurring” of liability for a hospital charge may *start* when an injured person accepts medical provider services. However, the injured person’s liability for hospital charges is, at that point, merely inchoate. That injured person’s liability becomes complete only when the bill is calculated and submitted.

F. Caveat: Special Concern for Coordinated Medical Billing Situations

Where there is coordinated medical benefits coverage, the primary health insurer, for example, Blue Cross Blue Shield (“BCBS”), is responsible for the medical bills of the injured person. In these

situations, BCBS must pay the medical bill once it has been calculated and submitted by the medical service provider. The No-Fault insurer will not pay any medical benefits unless and until it receives an "Explanation of Benefits" from BCBS, which explains the injured person's balance - i.e., "what the injured person is liable for". See Sinas & Miller, Motor Vehicle No-Fault Law in Michigan (2007 ed), pp 232-252. The patient pay balance is what the injured person is liable for, and therefore, is the amount that the no-fault insurer must pay.

Therefore, in these situations, the injured person's liability, if any, is determined after the primary insurer pays and prepares an Explanation of Benefits. Accordingly, if this Honorable Court deems an expense is "incurred" at the time service is rendered, the one-year back provision will be shortened even more. This is just one more reason to find that an expense is "incurred" at the time the bill is calculated and submitted in the medical service provider context.


CONCLUSION AND RELIEF REQUESTED

This Honorable Court should find that, in the medical provider context, an expense is not incurred until the expense is computed and submitted, rather than at the time each service is rendered.

Respectfully submitted.

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MILLER & TISCHLER, P.C.
Attorneys for CPAN

 (P49966)
BY: WAYNE J. MILLER (P31112)
26711 Northwestern Hwy., Suite 200
Southfield, MI 48033-2159
(248) 945-1040